

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

1003

11503

-62-044879

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

Registrar's No.

FILED DEC 7 1962

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. Louis</u>		c. CITY OR TOWN <u>ST. Louis</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. Louis CITY HOSP.</u>		d. STREET ADDRESS (If outside, give location) <u>1405 Missouri</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>RUBEN</u> Middle <u>SIZEMORE</u> Last		4. DATE OF DEATH Month <u>Nov</u> Day <u>28</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 23, 1911</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED ORDERLY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CITY HOSP.</u>	11. BIRTHPLACE (City and state or country) <u>BUNKER, MO.</u>
13a. FATHER'S NAME <u>CHARLES SIZEMORE</u>		13b. MOTHER'S MAIDEN NAME <u>SALLIE PARKER</u>	14. NAME OF HUSBAND OR WIFE <u>MYRTLE SIZEMORE</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>9030-20</u>	
17. INFORMANT <u>VIRGINIA SOAIB</u>		Address <u>2237 INDIANA</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture of the skull with softening and degeneration of brain tissue; old chronic Myocarditis; Right upper lobe pneumonia. Suffered in fall to ground in part of about 1635 S Jefferson, on November 9, 1962</u> DUE TO (b) <u>Accident</u> DUE TO (c) <u>9030-20</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u>11</u> a.m. Month, Day, Year <u>11-9-62</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Street</u> <u>23</u>		20f. CITY, TOWN, OR LOCATION <u>ST. Louis, Mo.</u>	
21. I attended the deceased from <u>3:00 A</u> to <u>her</u> and last saw him alive on <u>her</u>		Death occurred at <u>3:00 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>Nelson L. Taylor, Coroner</u>		22b. ADDRESS <u>1300 Clark Ave.</u>	
22c. DATE SIGNED <u>11-30-62</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	
23b. DATE <u>Nov 30 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>NATIONAL CEM.</u>	
23d. LOCATION (City, town, or county) (State) <u>JEFFERSON BRK'S Mo.</u>		24. FUNERAL DIRECTOR <u>Sherman Rutis</u>	
25. DATE RECD. BY LOCAL REG. <u>NOV 30 1962</u>		26. REGISTRAR'S SIGNATURE <u>Head Smith Mo</u>	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK  
OR  
TYPEWRITER RIBBON

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Rev. 4/59

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RECEIVED

Certified Case

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Boily Thompson*

Licensed Embalmer No. 4861

P. O. Address St. Louis 19, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.